Complete Summary

GUIDELINE TITLE

Incorporating HIV prevention into the medical care of persons living with HIV. Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America.

BIBLIOGRAPHIC SOURCE(S)

Incorporating HIV prevention into the medical care of persons living with HIV. Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Soc. MMWR Recomm Rep 2003 Jul 18;52(RR-12):1-24. [249 references] PubMed

Recommendations for incorporating human immunodeficiency virus (HIV) prevention into the medical care of persons living with HIV. Clin Infect Dis 2004 Jan 1;38(1):104-21. [165 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Human immunodeficiency virus (HIV) transmission

GUIDELINE CATEGORY

Counseling
Prevention
Risk Assessment
Screening

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Internal Medicine
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Health Plans
Hospitals
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

- To present general recommendations for incorporating human immunodeficiency virus (HIV) prevention into the medical care of all HIV-infected adolescents and adults, regardless of age, sex, or race/ethnicity
- To prevent HIV transmission by HIV-infected persons

TARGET POPULATION

HIV-infected adolescents and adults, regardless of age, sex, or race/ethnicity

INTERVENTIONS AND PRACTICES CONSIDERED

Screening

1. Screening for HIV transmission risk behaviors, by brief self-administered written questionnaires; computer-, audio-, and video-assisted questionnaires; structured face-to-face interviews; and personalized discussions
2. Screening for sexually transmitted diseases (STD´s), including laboratory testing (rapid plasma regain [RPR], Venereal Disease Research Laboratory [VDRL] test; cultures; nucleic acid amplification test [NAAT]; wet mount examination)

3. Screening for pregnancy

Counseling/Prevention

1. Behavioral interventions to reduce human immunodeficiency virus (HIV) transmission risk (communicating prevention messages; discussing sexual and drug-use behavior; reinforcing changes to safer behavior; referring patients for services such as substance abuse treatment)
2. Partner counseling and referral, including partner notification, counseling and testing
3. Identify and treat other sexually transmitted diseases

MAJOR OUTCOMES CONSIDERED

- Sensitivity and effectiveness of screening methods
- Effectiveness of behavioral interventions
- Effectiveness of partner counseling and referral services

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

I. Evidence from at least one properly randomized, controlled trial
II. Evidence from at least one well-designed clinical trial without randomization, from cohort or case-controlled analytic studies (preferably from more than one center), or from multiple time-series studies. Or dramatic results from uncontrolled experiments
III. Evidence from opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

A. Should always be offered. Both strong evidence for efficacy and substantial benefit support recommendation for use.
B. Should generally be offered. Moderate evidence for efficacy — or strong evidence for efficacy but only limited benefit — supports recommendation for use.
C. Optional. Evidence for efficacy is insufficient to support a recommendation for use.
D. Should generally not be offered. Moderate evidence for lack of efficacy or for adverse outcome supports a recommendation against use.
E. Should never be offered. Good evidence for lack of efficacy or for adverse outcome supports a recommendation against use.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (I-III) and grades of recommendation (A-E) ratings are defined at the end of the Major Recommendations field.

Recommendations for Screening of Human Immunodeficiency Virus (HIV)-infected Persons for HIV Transmssion Risk

HIV-infected patients should be screened for behaviors associated with HIV transmission by using a straightforward, nonjudgmental approach. This should be done at the initial visit and subsequent routine visits or periodically, as the clinician feels necessary, but at a minimum of yearly. Any indication of risky behavior should prompt a more thorough assessment of HIV transmission risks. (A-II, for identifying transmission risk)

At the initial and each subsequent routine visit, HIV-infected patients should be questioned about symptoms of sexually transmitted diseases (STDs) (e.g., urethral or vaginal discharge; dysuria; intermenstrual bleeding; genital or anal ulcers; anal pruritus, burning, or discharge; and, for women, lower abdominal pain with or without fever). Regardless of reported sexual behavior or other epidemiologic risk information, the presence of such signs or symptoms should always prompt diagnostic testing and, when appropriate, treatment. (A-I, for identifying and treating STDs)

At the initial visit

- All HIV-infected women and men should be screened for laboratory evidence of syphilis. Women should also be screened for trichomoniasis. Sexually active women aged $\leq$25 years and other women at increased risk, even if asymptomatic, should be screened for cervical chlamydial infection. (A-II, for identifying STDs)
- Consideration should be given to screening all HIV-infected men and women for gonorrhea and chlamydial infections. However, because of the cost of screening and the variability of prevalence of these infections, decisions about routine screening for these infections should be based on epidemiologic factors (including prevalence of infection in the community or the population being served), availability of tests, and cost. (Some HIV specialists also recommend type-specific serologic testing for herpes simplex virus type 2 for both men and women.) (B-II, for identifying STDs)

Screening for STDs should be repeated periodically (i.e., at least annually) if the patient is sexually active or if earlier screening revealed STDs. Screening should be done more frequently (e.g., at 3–6-month intervals) for asymptomatic persons at higher risk. (B-III, for identifying STDs)

At the initial and each subsequent routine visit, HIV-infected women of childbearing age should be questioned to identify possible current pregnancy, interest in future pregnancy, or sexual activity without reliable contraception. They should be referred for appropriate counseling, reproductive health care, or prenatal care, as indicated. Women should be asked whether they suspect pregnancy or have missed their menses and, if so, should be tested for pregnancy. (A-I, for preventing perinatal HIV transmission)

Recommendations for Behavioral Interventions to Reduce HIV Transmission Risk

Clinics or office environments where patients with HIV infection receive care should be structured to support and enhance HIV prevention. (B-III, for enhancing patient recall of prevention messages)

Within the context of HIV care, brief general HIV prevention messages should be regularly provided to HIV-infected patients at each visit, or periodically, as determined by the clinician, and at a minimum of twice yearly. These messages should emphasize the need for safer behaviors to protect their own health and the health of their sex or needle-sharing partners, regardless of perceived risk. Messages should be tailored to the patient´s needs and circumstances. (A-III, for efficacy in promoting safer behaviors)

Patients should have adequate, accurate information regarding factors that influence HIV transmission and methods for reducing the risk for transmission to others, emphasizing that the most effective methods for preventing transmission are those that protect noninfected persons against exposure to HIV (e.g., sexual abstinence; consistent and correct use of condoms made of latex, polyurethane or other synthetic materials; and sex with only a partner of the same HIV serostatus). HIV-infected patients who engage in high-risk sexual practices (i.e., capable of resulting in HIV transmission) with persons of unknown or negative HIV serostatus should be counseled to use condoms consistently and correctly. (A-III, for using brief clinician delivered messages to influence patient behavior)

Patients´ misconceptions regarding HIV transmission and methods for reducing risk for transmission should be identified and corrected. For example, ensure that patients know that 1) per-act estimates of HIV transmission risk for an individual patient vary according to behavioral, biologic, and viral factors; 2) highly active antiretroviral therapy (HAART) cannot be relied upon to eliminate the risk of transmitting HIV to others; and 3) nonoccupational postexposure prophylaxis is of uncertain effectiveness for preventing infection in HIV-exposed partners. (A-III for using brief clinician delivered messages to influence patient behavior)

Tailored HIV prevention interventions, using a risk-reduction approach, should be delivered to patients at highest risk for transmitting HIV. (A-III, for efficacy in promoting safer behaviors)

After initial prevention messages are delivered, subsequent longer or more intensive interventions in the clinic or office should be delivered, if feasible. (A-I, for efficacy of multisession, clinic-based interventions in promoting safer behaviors)

HIV-infected patients should be referred to appropriate services for issues related to HIV transmission that cannot be adequately addressed during the clinic visit. (A-I, for efficacy of HIV prevention interventions conducted in nonclinic settings)

Persons who inject illicit drugs should be strongly encouraged to cease injecting and enter into substance abuse treatment programs (e.g., methadone maintenance) and should be provided referrals to such programs. (A-II, for reducing risky drug use and associated sexual behaviors)

Persons who continue to inject drugs should be advised to always use sterile injection equipment and to never reuse or share needles, syringes, or other

injection equipment and should be provided information regarding how to obtain new, sterile syringes and needles (e.g., syringe exchange programs). (A-II, for reducing risk for HIV transmission)

Recommendations for Partner Counseling and Referral, Including Partner Notification

In HIV health-care settings, all applicable requirements for reporting sex and needle-sharing partners of HIV-infected patients to the appropriate health department should be followed. (A-III, for identifying patients who should be referred for partner counseling and referral services [PCRS])

At the initial visit, patients should be asked if all of their sex and needle-sharing partners have been informed of their exposure to HIV. (A-III, for identifying patients who should be referred for PCRS)

At routine follow-up visits, patients should be asked if they have had any new sex or needle-sharing partners who have not been informed of their exposure to HIV. (A-III, for identifying patients who should be referred for PCRS)

All patients should be referred to the appropriate health department to discuss sex and needle-sharing partners who have not been informed of their exposure and to arrange for their notification and referral for HIV testing. (A-I, for increasing partner counseling and referral and voluntary testing of partners)

In HIV health-care settings, access to available community partner counseling and referral resources should be established. (A-III, for establishing a working relationship and increasing understanding about partner counseling and referral procedures)

Definitions:

Strength of Evidence Supporting the Recommendation

I. Evidence from at least one properly randomized, controlled trial
II. Evidence from at least one well-designed clinical trial without randomization, from cohort or case-controlled analytic studies (preferably from more than one center), or from multiple time-series studies. Or dramatic results from uncontrolled experiments
III. Evidence from opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees

Strength of Recommendation

A. Should always be offered. Both strong evidence for efficacy and substantial benefit support recommendation for use.
B. Should generally be offered. Moderate evidence for efficacy — or strong evidence for efficacy but only limited benefit — supports recommendation for use.
C. Optional. Evidence for efficacy is insufficient to support a recommendation for use.

D. Should generally not be offered. Moderate evidence for lack of efficacy or for adverse outcome supports a recommendation against use.
E. Should never be offered. Good evidence for lack of efficacy or for adverse outcome supports a recommendation against use.

CLINICAL ALGORITHM(S)

Two algorithms are provided in the original guideline document:

- Example of Tailoring Messages Regarding Condom Use for Sexually Active, HIV-infected Persons
- Example of Tailoring Messages Regarding Needle Sharing for HIV-infected Persons who Continue to Inject Drugs

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- This guideline may help health care providers incorporate human immunodeficiency virus (HIV) prevention into the medical care of persons living with HIV.
- Through ongoing attention to prevention, risky sexual and needle-sharing behaviors among persons with HIV infection can be reduced and transmission of HIV infection prevented.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- In conducting risk screening, clinicians should recognize that risk is not static. Patients´ lives and circumstances change, and a patient´s risk of transmitting human immunodeficiency virus (HIV) may change from one medical encounter to another. Also, clinicians should recognize that working with adolescents may require special approaches and should be aware of and adhere to all laws and regulations related to providing services to minors.
- Local and state health departments have reporting requirements for HIV and other sexually transmitted diseases (STDs), which vary among states. Clinicians should be aware of and comply with requirements for the areas in

which they practice; information on reporting requirements can be obtained from health departments.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Clinical Algorithm

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

RELATED QUALITY TOOLS

- A Pocket Guide to Adult HIV/AIDS Treatment: Companion to A Guide to Primary Care of People with HIV/AIDS August 2004 Edition

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Incorporating HIV prevention into the medical care of persons living with HIV. Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Soc. MMWR Recomm Rep 2003 Jul 18;52(RR-12):1-24. [249 references] PubMed

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Jul 18

GUIDELINE DEVELOPER(S)

Centers for Disease Control and Prevention - Federal Government Agency [U.S.]
Health Resources and Services Administration - Federal Government Agency [U.S.]
Infectious Diseases Society of America - Medical Specialty Society
National Institutes of Health (U.S.) - Federal Government Agency [U.S.]

SOURCE(S) OF FUNDING

United States Government

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The preparers of this report have no conflict of interest with the manufacturers or products discussed herein.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site:

- HTML Format
- Portable Document Format (PDF)

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was prepared by ECRI on January 7, 2004. The information was verified by the guideline developer on January 27, 2004.

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